

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1677

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01661

Reg. Dist.

No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkton</u>	LENGTH OF STAY (in this place) <u>40 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Elkton</u>	TOWN <u>Elkton</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>237 E Main St</u>		STREET ADDRESS (If rural, give location) <u>237 E Main St</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>SARRETT</u>	(Middle) <u>AMOS</u>	(Last) <u>ALLENDER</u>	(Month) <u>2</u> (Day) <u>20</u> (Year) <u>1956</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>12-1-1891</u>
9. AGE last birthday: <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of both life) <u>farm mill owner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>brand feeds</u>	
11. BIRTHPLACE (State or foreign country): <u>Harford Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S C</u>	
13. FATHER'S NAME: <u>James Allen der.</u>		14. MOTHER'S MAIDEN NAME: <u>Charlotte Cloman.</u>	
15. (Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: _____	
17. INFORMANT & ADDRESS: <u>Clara E. Allender 237 E Main St Elkton Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute coronary Occlusion</u>			
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause (c) _____			
stating underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: _____		19b. MAJOR FINDING OF OPERATION: _____	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) _____ (County) _____ (State) _____	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>R. L. Woodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-20-56</u> ASSISTANT MEDICAL EXAM. _____	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>2-23-56</u>	NAME OF CEMETERY OR CREMATORY: <u>Elkton Cemetery</u>	LOCATION (City, town, or county) (State): <u>Elkton Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 23</u>	REGISTRAR'S SIGNATURE: <u>J. H. Trager</u>	24. FUNERAL DIRECTOR: <u>Pippin Funeral Home</u> ADDRESS: <u>259 E. Main St Elkton, Md.</u>	
		W. A. Lusby	

REAU V. S.

FEB 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

01662

2411 N. Charles Street, Baltimore

1678

CERTIFICATE OF DEATH

Reg. Dist. No. *92*

1. PLACE OF DEATH- COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md.</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>110 Bridge St.</i>		STREET ADDRESS (If rural, give location) <i>110 Bridge St.</i>	
3. NAME OF DECEASED (First) <i>Addison</i> (Middle) (Last) <i>Atkinson</i>		4. DATE OF DEATH (Month) <i>Feb.</i> (Day) <i>16</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 23, 1871</i>
9. AGE last birthday <i>84</i> yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <i>Hotel Prop.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Francis Atkinson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Dennison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>—</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Thomas Carr, Elkton, Md.</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

610X Immediate cause

(a) *cerebral hemorrhage*

INTERVAL BETWEEN ONSET AND DEATH

1 day.

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

(b) *sub-acute glomerular nephritis**6 yrs.*(c) *Hypertrophy of Prostate**6 yrs.*

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *9/20*, 19*50*, to *2/16*, 19*56*, that I last saw the deceased alive on *2/15*, 19*56*, and that death occurred at *9:00* A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>2/18/56</i>	<i>Cherry Hill Methodist Cem</i>	<i>Cherry Hill</i>	<i>Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<i>Feb 18</i>	<i>H. H. Frazier</i>	<i>H. Walter du Bone, Jr.</i>	<i>Elkton, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 20 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1689

01663
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hottelburg MD Pa.</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Hottelburg MD Pa.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lombard</u>				STREET ADDRESS (If rural, give location) <u>Lombard Md.</u>			
3. NAME OF DECEASED: (First) <u>FRED</u> (Middle) <u>C</u> (Last) <u>BARRETT</u>				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>3-27-1878</u>	
9. AGE last birthday: <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Cecil Co Ind.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>Superintendent</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Samuel Fletcher Barrett</u>				14. MOTHER'S MAIDEN NAME: <u>Melbena Irwin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Margaret Barrett, Hotellburg Pa.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral Thrombosis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>A. L. Dodson</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>2-8-56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Friends Burial Ground, Calvert Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>Feb 9-56</u>		REGISTRAR'S SIGNATURE: <u>L. M. Northington</u>		24. FUNERAL DIRECTOR: <u>William G. Johnston, Oxford Pa.</u>		ADDRESS:	

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FEB 14 1956

BUREAU A. S.

1690

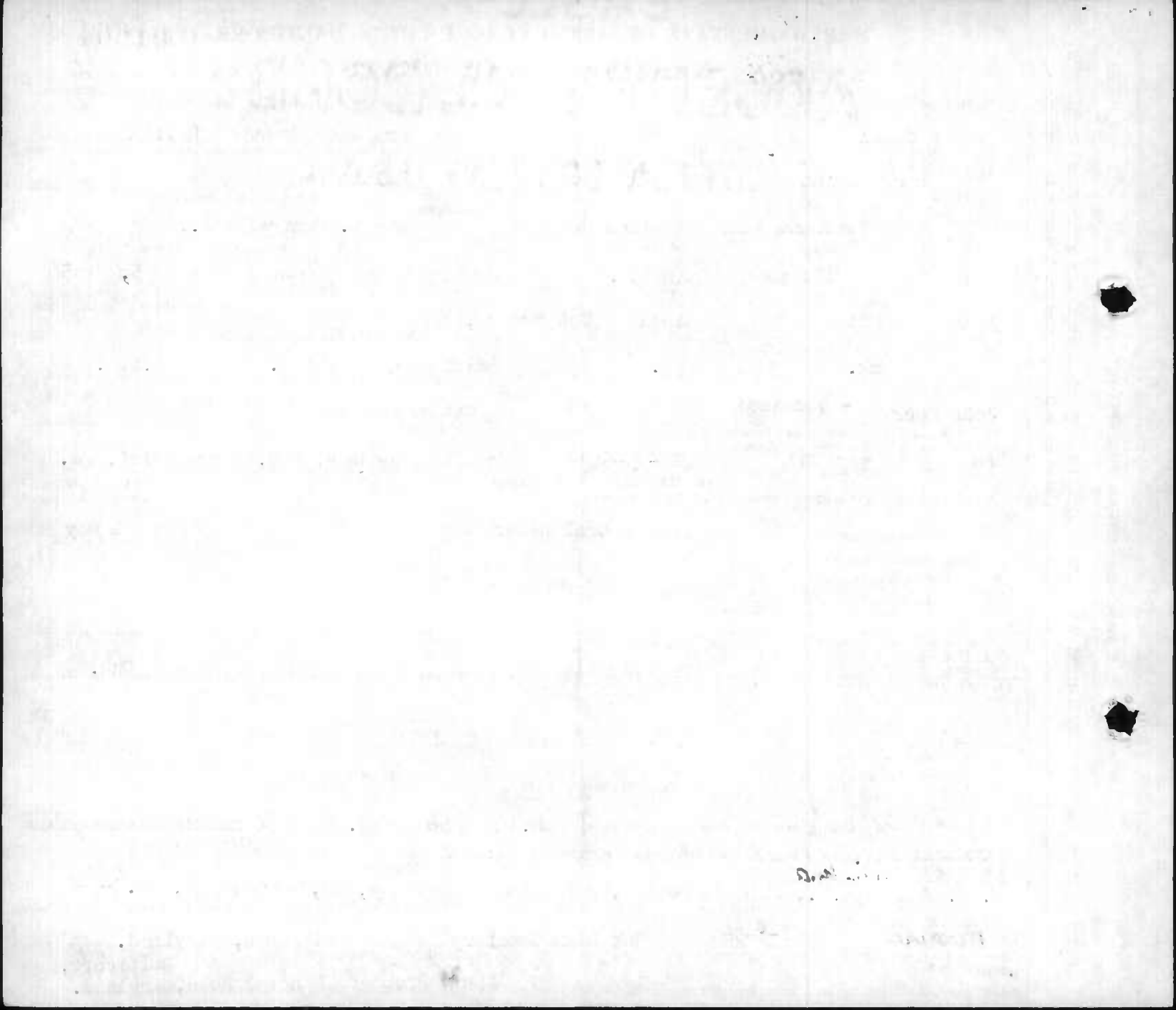
CERTIFICATE OF DEATH

Reg. Dist. No. ... 96.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Perry Point</u>		21 Days		OR TOWN <u>Baltimore</u> 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 <u>Veterans Administration Hospital</u>				405 S. Central Ave.,			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>William (NMI) Beck</u>				<u>February 5, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>October 30, 1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Unk.</u>		<u>Unk.</u>		<u>Baltimore, Maryland.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Beck - Deceased</u>				<u>Catherine Tine - Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u> <u>WW1</u>		<u>220-03-5409</u>		<u>Hospital Records, VAH, Perry Point, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>1 Day</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Aplastic anemia</u>						<u>Unk.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from <u>Jan. 16, 1956</u> to <u>Feb. 5, 1956</u> , and that death occurred at <u>11:25 AM</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>W. M. HARRIS, M.D.</u>		<u>VAH, Perry Point, Md.</u>		<u>2-5-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-8-56</u>		<u>Oak Lawn Cemetery</u>		<u>Baltimore, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2/6/56</u>		<u>G. W. Hedrick</u>		<u>Dippel Brothers</u>		<u>Baltimore, Maryland.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 1691
 CERTIFICATE OF DEATH

01665
 91
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MD</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H.</u> Last <u>BOLTON</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1877</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. BOLTON</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-12-9857</u>		17. INFORMANT Address <u>MRS. MAGGIE BOLTON - CECILTON - MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Feb 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 29</u> , 19 <u>56</u> , and that death occurred at <u>3 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u>				ADDRESS (Street, city or town, state) <u>Cecilton, md.</u> DATE SIGNED <u>3 Mar 1956</u>			
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHNTOWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL EARLEVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows - Millington, Md</u>				24a. REC'D BY REGISTRAR DATE <u>Mar. 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Ralph Rees</u>	

BUREAU V. S.

7 MAR 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

1679

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01666

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>227 W. Main St.</u>		STREET ADDRESS (If rural, give location) <u>227 W. Main St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle) <u>W.</u>	(Last) <u>Boulden</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-8-1869</u>
			9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Boat Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William T. Boulden</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Boulden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-26-0100</u>	
		17. INFORMANT AND ADDRESS <u>Layton T. Boulden 227 W. Main St. Elkton Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Pulmonary Edema</u>	<u>1 day</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Cerebral hemorrhage</u>	<u>11 mos.</u>
	(c) <u>Coronary vascular renal</u>	<u>10 years</u>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25, 1956, to 2/14, 1957, that I last saw the deceased alive on 2/14, 1956, and that death occurred at 5:05 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2-18-56</u>	<u>Elkton Cemetery</u>	<u>Elkton</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb 17</u>	<u>HR. J. J. J.</u>	<u>Pippin Funeral Home</u>	<u>259 E Main St. Elkton, Md.</u>	

W. A. Lusk

RECEIVED

FEB 20 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01667

Reg. Dist.

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Leecil</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Leecil</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Port Deposit Md</i>	LENGTH OF STAY (in this place) <i>5 mo</i>	CITY (If outside corporate limits write RURAL OR TOWN) <i>Port Deposit Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Grace View Farm</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) <i>MARY</i> (Middle) <i>CHRISTINE</i> (Last) <i>BOUYER</i>		4. DATE OF DEATH (Month) <i>2</i> (Day) <i>17</i> (Year) <i>1956</i>	
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>10-3-1875</i>
9. AGE last birthday: <i>80</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Bedford Va.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. FATHER'S NAME: <i>Joseph J. Tate</i>		12. MOTHER'S MAIDEN NAME: <i>unknown</i>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <i>no</i>		14. SOCIAL SECURITY No.: <i>no</i>	
15. INFORMANT & ADDRESS: <i>Woy B. Anderson, Port Deposit Md</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Chronic hepatitis & Drapery</i> DUE TO			
Antecedent cause(s) (b) <i>giving rise to the above cause</i> DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>A. LeDocher</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>2-17-56</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <i>2-17-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Removal & Burial</i>	DATE THEREOF: <i>2-17-1956</i>	NAME OF CEMETERY OR CREMATORY: <i>Bedford</i>	LOCATION (City, town, or county) (State): <i>Bedford, Va</i>
DATE REC'D BY LOCAL REG. <i>2-17-1956</i>	REGISTRAR'S SIGNATURE: <i>Irene E. Dougherty</i>	24. FUNERAL DIRECTOR: <i>Lila Patterson Wilson, Brynild, Md</i>	ADDRESS:

BUREAU V. S.

FEB 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01668

1680 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>21</u> TOWN <u>Elkton</u>	<u>3 weeks</u>	<u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>145</u> <u>Union Hosp.</u>		<u>RFD # 3</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mary LOUISE RUSH Burne</u>		<u>Feb. 2 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>F.</u>	<u>W</u>	<u>Married</u>	<u>June 22, 1885</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>72</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housewife</u>		<u>at home</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Sheraton Pa</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Patrick Rush</u>		<u>Catherine Mc Dermott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
<u>Thomas D. Burne Elkton, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombus</u>			<u>Jan. 17-56</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 30, 1955</u> to <u>Feb. 2, 1956</u> , that I last saw the deceased alive on <u>Feb. 1, 1956</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Wilford H. Sprecher, M.D.</u>		ADDRESS <u>Elkton Md</u>	
DATE SIGNED <u>Feb 2</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>Feb 4, 1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cathedral Cem.</u>		<u>Sheraton, Lachawanna Co. Pa</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Feb 2</u>		<u>FR Trague</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Proper & Sons</u>		<u>Elkton, Md</u>	

1957
7561
1883

BUREAU V. S.

FEB 6 1956

RECEIVED

1681

01669

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *92*

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Cecil</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Elkton</i>	LENGTH OF STAY (in this place) <i>2 hours</i>	CITY (If outside corporate limits write RURAL and give nearest town) <i>Elkton</i>	TOWN <i>21</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>		STREET ADDRESS (If rural, give location) <i>12-Curtis Lane</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>DANIEL</i>	(Middle)	(Last) <i>BUTLER</i>	(Month) <i>2</i> (Day) <i>6</i> (Year) <i>1956</i>
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>	8. DATE OF BIRTH: <i>3-19-1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>General</i>	9. AGE last birthday: <i>68</i> yrs.
11. BIRTHPLACE (State or foreign country): <i>Elkton Md.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John Butler</i>		14. MOTHER'S MAIDEN NAME: <i>Martha Simbel</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY No.: <i>212-12-9880A</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Mary E Butler Curtis Lane Elkton Md.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Cerebral Accident</i> DUE TO Antecedent cause(s) (b) <i>hypertension</i> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>R. L. Woodson</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>2-7-56</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>2/9/56</i>	NAME OF CEMETERY OR CREMATORY <i>Elkton Cemetery</i>
LOCATION (City, town, or county) (State) <i>Elkton Md.</i>	24. FUNERAL DIRECTOR <i>Pippin Funeral Home</i>	ADDRESS <i>259 E Main St Elkton, Md.</i>
DATE REC'D BY LOCAL REG. <i>Feb 9</i>	REGISTRAR'S SIGNATURE <i>H. J. Frazer</i>	<i>Wm. A. Rusby</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

FEB 14 1936

RECEIVED

1682 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

COUNTY CECIL MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) ELKTON LENGTH OF STAY (in this place) 2 weeks
 HOSPITAL OR INSTITUTION OR STREET ADDRESS UNION Hospital ELKTON, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY CECIL
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELKTON MILLS
 STREET ADDRESS (If rural give location) _____

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause

(a) DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

24 hours

3-4 mos

3-4 mos

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2, 1956, to 2-17, 1956, that I last saw the deceased alive on 2-17, 1956, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 20 1954

RECEIVED

1693 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY CECIL		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN PERRY POINT		(5 Yrs. 5 Months)		TOWN Baltimore City (25) 02X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 VETERANS ADMINISTRATION HOSPITAL				117 Zepplin Avenue			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Day) (Year)	
HEYWARD		W.		COOPER		2 12 19 56	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
MALE		NEGRO		MARRIED		8-8-22	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 24 HRS.	
33 yrs.		Months		Days		Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
Clerk				Postal Clerk			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Simpsonville, S. C.				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Unknown				Lucile Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
Yes				249 22 8817			
17. INFORMANT & ADDRESS:				Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
345X IMMEDIATE CAUSE (A) Malnutrition, severe, in persons over 2 yrs. of age						1-2-yrs.	
ANTECEDENT CAUSE (S) (B) Decubitus ulcers, multiple, over all bony prominences						5-6 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Multiple sclerosis						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from 9-8, 1950, to 2-12, 1956, and that death occurred at 9:00a M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
W. OPPLER, Director, Professional Services		VAH, Perry Point, Md.		2-13-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		2-13-56		Carver Memorial Park		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-14-56		Irene E. Dougherty		Pennington & Son, Havre de Grace, Md.			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 16 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1694 CERTIFICATE OF DEATH

01672

Reg. Dist. No. 91

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rising Sun, R.D.</i>		<i>20 yrs</i>		TOWN <i>Rising Sun, Rural</i>		<i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rt 276</i>				STREET ADDRESS (If rural give location) <i>Rt. 276</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <i>Cora Lee</i> (Middle) <i>Cowan</i> (Last)				<i>2-7-1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>4-27-1878</i>	<i>77</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Own Home</i>		<i>Virginia</i>		<i>USA</i>	
13. FATHER'S NAME <i>Kastrolk</i>				14. MOTHER'S MAIDEN NAME <i>Mollie Soble</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>no</i>				<i>-</i>		<i>Rex Cowan, Rising Sun, Md., R.D.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4343 IMMEDIATE CAUSE (A) <i>Pulmonary Edema</i>				INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardiac Decomensation</i>				<i>3 wks.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cirrhosis of Liver</i>				<i>6 yrs</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <i>1952</i> , 19 <i>217</i> , to <i>56</i> , 19 <i>56</i> that I last saw the deceased alive on <i>217</i> , 19 <i>56</i> , and that death occurred at <i>10A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Oneil Taylor</i> M.D.				ADDRESS (Street, city, town, state) <i>Rising Sun, Md.</i>		DATE SIGNED <i>2/9/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-10-1956</i>		NAME OF CEMETERY OR CREMATORY <i>Greenwell</i>		LOCATION (City, town, or county) (State) <i>Port Republic, Md. Rural</i>	
24. REC'D BY REGISTRAR <i>Feb 8-1956</i>		REGISTRAR'S SIGNATURE <i>L M Worthington</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Neer Patterson</i> ADDRESS <i>Smy, Perryville, Md.</i>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1683 CERTIFICATE OF DEATH

01673

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		STATE <u>Maryland</u> COUNTY <u>Cecil</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		LENGTH OF STAY (in this place) <u>1 Week</u>		TOWN <u>Elkton</u>		TOWN <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>104 South St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Arthur H. Denney</u>				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>October 12, 1888</u> <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Dover, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Denney</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Philipps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Charles Denney Elkton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio vascular renal</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1930</u> <u>2/7/</u> <u>56</u> to <u>2/7/</u> <u>56</u> that I last saw the deceased alive on <u>2/7/</u> <u>56</u> and that death occurred at <u>9:20p</u> M. from the causes and on the date stated above. SIGNATURE <u>Herbert Bates</u> ADDRESS (Street, city, town, state) <u>M.D. 230 E. main st. Elkton Md.</u> DATE SIGNED <u>2/8/56</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>2/11/56</u> NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u> LOCATION (City, town, or county) <u>Near Chesapeake City, Md.</u> 24. REC'D BY REGISTRAR <u>F. R. Traylor</u> REGISTRAR'S SIGNATURE <u>Pippin Funeral Home</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>259 E main st. Elkton Md.</u> DATE <u>Feb. 14, 1956</u> ADDRESS <u>Wm G. Lushky.</u>							

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1695

01674
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 94

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
X TOWN <u>North East Rd.</u>		<u>5 yrs.</u>		TOWN <u>North East Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Ruby MARSHALL Dixon</u>				(Month) (Day) (Year) <u>2 4 1956</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH: <u>9-29-1904</u>	
				9. AGE last birthday: <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY: <u>all kinds of mch. & electrical</u>		11. BIRTHPLACE (State or foreign country): <u>Cecil Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob Dixon</u>				14. MOTHER'S MAIDEN NAME: <u>Julia Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>312-12-0827</u>		17. INFORMANT & ADDRESS: <u>Walter Dixon, Wilmington Del.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>9238</p> <p>Immediate cause (a) <u>Drowned.</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OR arrest, office bldg., etc.) <u>Stoney Creek</u>		21c. (City or town) (County) (State) <u>North East Cecil Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>07 2 4 56 2 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in Creek North East Md.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. LeWoodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>2-6-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2-8-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Marks R.U.M.P.</u>		LOCATION (City, town, or county) (State) <u>North East Rd. Cecil Md.</u>	
DATE REC'D BY LOCAL REG. <u>2-8-1956</u>		REGISTRAR'S SIGNATURE <u>Sarah E. Rothman</u>		24. FUNERAL DIRECTOR <u>Joseph R. Evans</u>		ADDRESS <u>North East Md.</u>	

RECEIVED

FEB 10 1956

BUREAU V. 3

1696

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Perry Point		LENGTH OF STAY (in this place) 6mo. 24 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Myersville 10X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital				STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED: (First) JOSEPH		(Middle) R.		(Last) FARSHT		4. DATE (Month) (Day) (Year) OF DEATH: February 13 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married (Sep.)	8. DATE OF BIRTH: 1-29-18	9. AGE last birthday 38 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Unknown		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Mary (E) Grossnickel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes ✓ (If Yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Subarachnoid accumulation of cerebral						Approx. 5	
ANTECEDENT CAUSE (S) DUE TO spinal fluid (following operation)						Mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO Angioma of the cerebellum, probably						unknown	
STATING UNDERLYING CAUSE LAST. DUE TO congenital							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bronchopneumonia, right lower lobe						unknown	
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-20, 1955, to 2-13, 1956, and that death occurred at 1:35 AM, from the causes and on the date stated above. SIGNED W. OPPLER, Director, Professional Services, VAH, Perry Point, Md. DATE SIGNED 2-13-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 2-13-56		NAME OF CEMETERY OR CREMATORY Unknown		LOCATION (City, town, or county) (State) Myersville, Md.	
DATE REC'D BY LOCAL REGISTRAR Feb 13/1956		REGISTRAR'S SIGNATURE Irene E. Dougherty		24. FUNERAL DIRECTOR BITTLE FUNERAL HOME, Myersville, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1697 **CERTIFICATE OF DEATH**

01676

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Conowingo Rural</u>		<u>73 yrs.</u>		TOWN <u>Conowingo Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>William Albert Grubb</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 19 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 2 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Conowingo Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles A. Grubb</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Hess</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. William Grubb Conowingo, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>420.1 Recurrent Myocardial Infarction</u>						<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction 3 months ago</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Sclerosis</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/10</u> , 19 <u>55</u> , to <u>2/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>56</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul R. [Signature]</u>				ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u>		DATE SIGNED <u>2/21/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Penn Hill Friends</u>		LOCATION (City, town, or county) (State) <u>Near Conowingo Md.</u>	
24. REC'D BY REGISTRAR <u>Feb 20 - 56</u>		REGISTRAR'S SIGNATURE <u>L. M. [Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. [Signature]</u>		ADDRESS <u>Rising Sun, Md.</u>	

1904 CERTIFICATE OF DEATH

Wash. D.C. 20501

1. DEATH REPORTED BY (Name of Registrar)

2. NAME OF DECEASED
 3. SEX
 4. AGE
 5. OCCUPATION
 6. PLACE OF BIRTH
 7. DATE OF BIRTH
 8. PLACE OF DEATH
 9. CAUSE OF DEATH
 10. MANNER OF DEATH
 11. TIME OF DEATH
 12. TIME OF BURIAL
 13. PLACE OF BURIAL
 14. NAME OF MINISTER OF RELIGION
 15. NAME OF FUNERAL HOME
 16. NAME OF CEMETERY
 17. NAME OF COFFIN
 18. NAME OF CASKET
 19. NAME OF CASKET LINER
 20. NAME OF CASKET LID
 21. NAME OF CASKET LINER LID
 22. NAME OF CASKET LINER LID LID
 23. NAME OF CASKET LINER LID LID LID
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 28. NAME OF CASKET LINER LID LID LID LID LID LID LID LID
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 30. NAME OF CASKET LINER LID LID LID LID LID LID LID LID LID LID

11. TIME OF DEATH
 12. TIME OF BURIAL
 13. PLACE OF BURIAL
 14. NAME OF MINISTER OF RELIGION
 15. NAME OF FUNERAL HOME
 16. NAME OF CEMETERY
 17. NAME OF COFFIN
 18. NAME OF CASKET
 19. NAME OF CASKET LINER
 20. NAME OF CASKET LID
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 30. NAME OF CASKET LINER LID LID LID LID LID LID LID LID LID LID

21020423M

THIS CERTIFICATE IS TO BE FILLED OUT BY THE REGISTRAR OF DEATHS, AND IS TO BE SUBMITTED TO THE BOARD OF HEALTH, BALTIMORE, MARYLAND, FOR REVIEW AND APPROVAL. IT IS TO BE KEPT ON FILE IN THE OFFICE OF THE REGISTRAR, AND IS TO BE PRODUCED TO THE BOARD OF HEALTH, BALTIMORE, MARYLAND, AT THE REQUEST OF THE BOARD OF HEALTH, BALTIMORE, MARYLAND.

BUREAU V. S.

FEB 21 1906

RECEIVED

2.3.1.000

1698 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

COUNTY Cecil MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point LENGTH OF STAY (In this place) 4yrs. 2mo. 13days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) Landover Hills

STREET ADDRESS (If rural give location) 7120 Allison

3. NAME OF DECEASED:

(First)

MARVIN

(Middle)

J.

(Last)

GUYOT

4. DATE OF DEATH:

(Month)

February 15

(Day)

1956

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

8-19-1881

9. AGE last birthday

74 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Silver Smith

10B. KIND OF BUSINESS OR INDUSTRY:

Oneida Silver Co.

11. BIRTHPLACE (State or foreign country):

New York

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John B. Guyot - Deceased

14. MOTHER'S MAIDEN NAME:

Mary Donahue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

Yes

(If Yes, give war or dates of service)

Spanish American unknown

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Hospital Records, VAH, Perry Point, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A)

Arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

14 days

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Arteriosclerosis, general

unknown

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

VA

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-2, 1951, to 2-15, 1956, and that death occurred at 9:25 PM, from the causes and on the date stated above.

SIGNATURE

W. OPPLER, Director, Professional Services

ADDRESS

VAH, Perry Point, Md.

DATE SIGNED

2-16-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Removal

DATE THEREOF

2-16-56

NAME OF CEMETERY OR CREMATORY

Valley View

LOCATION (City, town, or county)

Sherrill, New York

(State)

DATE REC'D BY LOCAL REGISTRAR

2-16-56

REGISTRAR'S SIGNATURE

Irene Erbaugh

24. FUNERAL DIRECTOR

Pennington & Son, Havre de Grace, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 20 1956

RECEIVED

1699

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Colora, Rural</u>		67 yrs.		X <u>Colora, Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
John Armstrong Hindman				Feb. 6 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
Male	White	Single	Dec. 21, 1888	67 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farm Owner		Colora, Md.		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel Hindman				Frances Craig			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				Sarah Hindman Colora, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO							3 yrs
ANTECEDENT CAUSE (S) DUE TO							4.11
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 4, 1953 to Feb 6, 1956 that I last saw the deceased alive on Feb 4, 1956 and that death occurred at 2 P. M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
F.P. Modgrass		M. D.		Washington Mt.		2/6/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 9, 1956		West Nottingham		Near Colora, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb 7 56		K. M. Nottingham		J. Earl Tyson		Boring Sun Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01679
1700 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Perry Point		LENGTH OF STAY (in this place) 1 mo. 6 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 1722 McHenry			
3. NAME OF DECEASED: (First) (Middle) (Last) WILLIAM M. HOLTZNER				4. DATE (Month) (Day) (Year) OF DEATH: February 20 1956			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 6-17-96	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signal Corp.		10B. KIND OF BUSINESS OR INDUSTRY: Aberdeen Proving		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Ground, (Government) Benjamin Holtzner				14. MOTHER'S MAIDEN NAME: Mary Durbeck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 214-01-9875		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia, unresolved, right lower lobe						3 to 4 days	
ANTECEDENT CAUSE (S) (B) Brain tumor, left temporal lobe,						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) malignant, type undetermined						unknown	
Arteriosclerosis, general							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-14 , 19 56 , to 2-20 , 19 56 , and that death occurred at 6:50 AM , from the causes and on the date stated above.							
SIGNATURE W. OPLER		ADDRESS VAH, Perry Point, Md.		DATE SIGNED 2-20-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 2-20-56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2-20-56		REGISTRAR'S SIGNATURE Irene E. Dougherty		24. FUNERAL DIRECTOR Pennington & Son		ADDRESS Hayes & Grace, Md.	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 24 1956

RECEIVED

1

1684

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01680
92

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WELKTON				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 65 UNION HOSPITAL				d. STREET ADDRESS NORTH EAST X			
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD M JACKSON				4. DATE OF DEATH Month Day Year 2 - 27 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1880	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEAVER		10b. KIND OF BUSINESS OR INDUSTRY TEXTILE RET-26Ks		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME THEODORE JACKSON				14. MOTHER'S MAIDEN NAME ELIZABETH MEEKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Ellam Jackson North East Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus; Gastric Ulcer;							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 22 Feb , 19 56 , to 27 Feb , 19 56 , that I last saw the deceased alive on 26 Feb , 19 56 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md		DATE SIGNED 27 Feb 56			
PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-1-1956	22c. NAME OF CEMETERY OR CREMATORY METHODIST		22d. LOCATION (City, town, or county) (State) NORTH EAST CECIL, Md			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph P. Bennett North East Md			24a. REC'D BY REGISTRAR DATE 3/1/56	24b. REGISTRAR'S SIGNATURE FR Jagan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 2 1956

RECEIVED

1701

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Pennsylvania		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN Perry Point		3Bys. 4mo. 25days		TOWN Philadelphia			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 1542 Mohican			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
JOHN		MARTIN		LANG		OF DEATH February 2 19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widowed	6-23-84	71 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Sign Painter		Unknown		Pennsylvania		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Lang - Deceased				Katherine (?) - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Yes		Unknown		Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Septicemia, Staphylococcus hemolyticus						3 to 4 days	
ANTECEDENT CAUSE (S) DUE TO (clonical)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Abscess, periprostatic						7 to 10 days	
(C) Adenocarcinoma prostate						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
3 1-30-56		Pneumoencephalogram					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA		M.					
22. I hereby certify that I attended the deceased from 9-9-1922 to 2-2-1956, that I last saw the deceased on 2-15-56, and that death occurred at 2:15 P.M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
W. OPPLER, Director, Professional Services		VAH, Perry Point, Md.		2-6-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		2-4-56		Arlington National		Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-7-56		Irene E. Dougherty		Pennington & Son		Hyde de Grace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 9 1956

RECEIVED

1702 CERTIFICATE OF DEATH

01682
Reg. Dist. No. 98

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY <u>Prince Williamd</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Perry Point</u>	LENGTH OF STAY (in this place) <u>28 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Manassas</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veteran Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>313 Maple Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>DAVIDR L. LAWLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 4 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>September 16, 1909</u>
9. AGE last birthday: <u>46 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>School Board</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>EDWARD C. LAWLER</u>	
14. MOTHER'S MAIDEN NAME: <u>SARAH REBECCA LAWLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-II</u>	
16. SOCIAL SECURITY NO. <u>228 18 4811</u>		17. INFORMANT & ADDRESS: <u>Hospital Records, VAH., Perry Point, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia, bilateral, unresolved</u>			<u>4-5 Days</u>
ANTECEDENT CAUSE (S) (B) <u>Carcinomatosis</u>			<u>Unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma Urinary Bladder</u>			<u>Unknown</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that <u>VA</u> attended the deceased from <u>Jan. 7, 1956</u> , to <u>Febr. 4, 1956</u> , that <u>XXXXXX</u> saw the deceased <u>XXXXXX</u> , and that death occurred at <u>10:20AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>W.M. Harris, M.D.</u>		ADDRESS <u>Acting Director, Professional Services, VAH., Perry Point, Md.</u>	
DATE SIGNED <u>2-5-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		NAME OF CEMETERY OR CREMATORY <u>Stonewall Memory Garden</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-4-56</u>		LOCATION (City, town, or county) (State) <u>Manassas, Virginia.</u>	
REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>		24. FUNERAL DIRECTOR <u>XXXXXXXXXX</u>	
ADDRESS <u>Havre DeGrace, Md.</u>			

BUREAU V. 3

FEB 7 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01683

1685 CERTIFICATE OF DEATH

Items 11,12, 13,14, 15,16 Film 92 2-8-56 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Elkton</u>				TOWN <u>ELKTON, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>131 W. MAIN ST</u>				STREET ADDRESS (If rural give location) <u>131 W. MAIN</u>			
3. NAME OF DECEASED (Type or Print) <u>William F. Liebig</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 1 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 1909</u>	
				9. AGE last birthday <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Barbershop</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Paul Leibig</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Hamill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>W.W. II</u>				16. SOCIAL SECURITY NO. <u>213-05-4656</u>		17. INFORMANT & ADDRESS	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <u>Coronary Insufficiency</u>						<u>9 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Interstitial Nephritis</u>						<u>9 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Edema</u>						<u>6 months</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 5, 1955, to Feb 1, 1956, that I last saw the deceased alive on Feb 1, 1956, and that death occurred at 11:25 P.M. from the causes and on the date stated above.							
SIGNATURE <u>James Johnson</u>				ADDRESS (Street, city, town, state) <u>M.D. 245 E. High St, Elkton, Md</u>			
				DATE SIGNED <u>2/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 4/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>		LOCATION (City, town, or county) (State) <u>ELKTON, Md</u>	
24. REC'D BY REGISTRAR <u>Feb. 6, 1956</u>		REGISTRAR'S SIGNATURE <u>G. R. Freyer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Pippin & Son, By B. B. Thompson</u>			

01000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1935 CERTIFICATE OF DEATH

Dec. 2nd 1935

1. NAME OF DECEASED

MARYLAND
STATE DEPARTMENT OF HEALTH

2. PLACE OF DEATH

3. SEX
4. AGE
5. OCCUPATION
6. MARITAL STATUS
7. COLOR

8. DATE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. PLACE OF BIRTH
12. PLACE OF DEATH

13. NAME OF PHYSICIAN
14. NAME OF HOSPITAL
15. NAME OF NURSE

16. NAME OF CORONER
17. NAME OF JURY
18. NAME OF JUDGE

19. NAME OF WITNESS
20. NAME OF WITNESS
21. NAME OF WITNESS

22. NAME OF WITNESS
23. NAME OF WITNESS
24. NAME OF WITNESS

25. NAME OF WITNESS
26. NAME OF WITNESS
27. NAME OF WITNESS

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29. NAME OF WITNESS
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31. NAME OF WITNESS
32. NAME OF WITNESS
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49. NAME OF WITNESS
50. NAME OF WITNESS
51. NAME OF WITNESS

52. NAME OF WITNESS
53. NAME OF WITNESS
54. NAME OF WITNESS

BUREAU V. S.

FEB 6 1936

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **01684**
 No. **96**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE D. C.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
<input checked="" type="checkbox"/> TOWN Perry Point		D.O.A.		TOWN Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural, give location) 4405 - 8th Street, N.W.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
WALLIE (NMI) MC ELVEEN				February 28 19 56			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Negro		Married		11-29-96	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Paper Operator U.S. Gov't. Printing				11. BIRTHPLACE (State or foreign country): South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Wheeler McElveen - Deceased				14. MOTHER'S MAIDEN NAME: Sallie Mazon - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a).....		Acute coronary occlusion				Immediate	
DUE TO							
Antecedent cause(s) (b).....		Coronary arteriosclerosis severe				unknown	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....		DUE TO					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Alfred Roemer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-28-56	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF 2-29-56		NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Va.	
DATE REC'D BY LOCAL REG. 3-1-56		REGISTRAR'S SIGNATURE Lucene E. Dougherty		24. FUNERAL DIRECTOR Pennington & Son		ADDRESS Hayne de Grace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8

MAR 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1686

01685

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Eldon</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldon</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>65 Union Hospital, Eldon, Md.</u>				d. STREET ADDRESS <u>307 Penna Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>McNEAL</u> Last <u>McNEAL</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-24-1890</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Eldon, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Patrick Castello</u>				14. MOTHER'S MAIDEN NAME <u>Ella Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Vernon Mc Neal, Eldon, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Uremia</u> DUE TO (b) <u>Arteriosclerotic Cardio-Renal</u> DUE TO (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus + Anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-24</u> , 19 <u>56</u> , to <u>2-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-21</u> , 19 <u>58</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W MAIN, ELKTON, Md 21921-58</u> DATE SIGNED <u>Feb 27 1958</u>							
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.				PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pepin Funeral Home</u>				ADDRESS <u>259 E. Main St.</u>		24b. REGISTRAR'S SIGNATURE <u>L. R. Frazier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and complete page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. CHG. NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	

1704 CERTIFICATE OF DEATH

Reg. Dist. No.96.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil MARYLAND				STATE Michigan COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Perry Point				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Detroit			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 5425 McDougall Street			
3. NAME OF DECEASED: (First) (Middle) (Last) WILLIAM W. MILLER				4. DATE (Month) (Day) (Year) OF DEATH: February 8 19 56			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 12-14-86	
9. AGE last birthday 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator		11. BIRTHPLACE (State or foreign country): Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia, bilateral, unresolved							3-4 days
ANTECEDENT CAUSE (S) (B) Pulmonary infarction, multiple, bilateral							5-7 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Mural thrombus right auricular appendage							10-14 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary arteriosclerotic heart disease							unknown
Arteriosclerosis generalized							unknown
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that he attended the deceased from 6-4, 1945, to 2-8, 1956, and that death occurred at 11:15 PM, from the causes and on the date stated above.							
SIGNATURE W. OPPLER, Director, Professional Services				ADDRESS VAH, Perry Point, Md.			
DATE SIGNED 2-10-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 2-9-56		NAME OF CEMETERY OR CREMATORY Unknown		LOCATION (City, town, or county) (State) Detroit, Michigan	
DATE REC'D BY LOCAL REGISTRAR 2-10-56		REGISTRAR'S SIGNATURE Irene E. Dougherty		24. FUNERAL DIRECTOR PENNINGTON & SONS		ADDRESS Havre de Grace, Md.	

BUREAU V. B.

FEB 14 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01687

" 1687 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Becil</u>	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edison</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES</u> <u>MUNN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>6</u> <u>1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Ind.</u>
13. FATHER'S NAME: <u>no information</u>		14. MOTHER'S MAIDEN NAME: <u>no information</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hoop Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>			<u>10 years?</u>
ANTECEDENT CAUSE (B):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>27 Jan</u> , 19 <u>56</u> , to <u>6 Feb</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Feb</u> , 19 <u>56</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Klaus H. Hachner M.D.</u>		DATE SIGNED <u>6 Feb '56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	

FEB 15 1956

REGISTRAR'S SIGNATURE

F. R. Hager

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

FEB 16 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01688 Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Beecil</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>Chester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Calvert</i>	LENGTH OF STAY (in this place) <i>6 mo</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>W. Bradford Township</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Gray heal nursing Home</i>		STREET ADDRESS (If rural, give location) <i>Rd #4 West Chester</i>	
3. NAME OF DECEASED: (Type or Print) <i>ALBERT</i> (First) <i>C</i> (Middle) <i>PASS</i> (Last)		4. DATE OF DEATH (Month) <i>2</i> (Day) <i>11</i> (Year) <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>6-11-1875</i>
9. AGE last birthday: <i>80</i> yrs.		IF UNDER 1 YEAR: Months <i>8</i> Days <i>8</i> Hours <i>11</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gen. Lab.</i>	11. BIRTHPLACE (State or foreign country): <i>Chester Co Pa.</i>
13. FATHER'S NAME: <i>John. Pass.</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah E. Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Chas. H. Pass. Manorbrook Pa.</i>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>Acute Coronary Occlusion</i>			
DUE TO			
Antecedent cause(s) (b) <i>—</i>			
Diseases or conditions, if any, giving rise to the above cause (c) <i>—</i>			
stating underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
<i>4-20-1</i>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>J. L. Woodson</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>2-13-56</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>Feb 13 1956</i>	NAME OF CEMETERY OR CREMATORY <i>Marshall Rd</i>	LOCATION (City, town, or county) (State) <i>W. Bradford Township Pa</i>
DATE REC'D BY LOCAL REG. <i>Feb 13-1956</i>	REGISTRAR'S SIGNATURE <i>L. M. Worthington</i>	24. FUNERAL DIRECTOR <i>Ralph M. Reed Rising Sun, Md.</i> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1936

BUREAU A. E.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01689

1688

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>DELAWARE</u>		COUNTY <u>NEW CASTLE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ELKTON</u>		<u>2 HRS</u>		TOWN <u>NEWARK</u>		<u>46 X - 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>65 UNION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>2106 BARKSDALE ROAD</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Boy Philhower</u>				<u>Feb. 23 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>Feb. 23, 1956</u>	<u>2 years</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>NONE</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM PHILHOWER</u>				<u>BETTY J. CORKRAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>WM PHILHOWER 2106 BARKSDALE RD NEWARK, DEL.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1776X IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 23, 1956</u>, to <u>Feb 23, 1956</u>, that I last saw the deceased alive on <u>Feb 23, 1956</u>, and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Dr. J. D. Jones</u> M.D.				<u>Elkton, Md</u>		<u>Feb. 24, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB. 25, 1956</u>		<u>WHITE CLAY CREEK</u>		<u>NEWARK, DEL.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 1 1956</u>		<u>L. R. Gray</u>		<u>R. T. Jones</u>		<u>Newark, Del</u>	

2065296383

0108

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

1008

Reg. Dist. No.

Official Record No.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

BUREAU V. S.

MAR 1 1956

RECEIVED

NOTIFICATION

At the time of death, the deceased was residing at the place of death, and was in the possession of his or her mind and faculties. The death was caused by the disease or condition specified in the certificate of death, and was not the result of violence, suicide, or homicide. The death was reported to the health officer by the attending physician, or other person authorized to report deaths, and was registered in the death records of the State Department of Health. The death was certified by the health officer, and the certificate of death was issued to the family of the deceased. The death was reported to the health officer by the attending physician, or other person authorized to report deaths, and was registered in the death records of the State Department of Health. The death was certified by the health officer, and the certificate of death was issued to the family of the deceased.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1706 CERTIFICATE OF DEATH

01690

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Cecil</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Allegany</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Port Deposit</i>	<i>3 mos</i>	TOWN <i>Western Port</i>	<i>02-43</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3 N. Main St</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>Ernest S. Richel</i>		<i>2 15 19 56</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Sept. 29, 1887</i>
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<i>68 yrs.</i>		<i>paper maker</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Michigan</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Unknown</i>		<i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<i>2-17-05-9224</i>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<i>Cornelia C. Richel, Port Deposit Md</i>		1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		<i>422.2 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u></i>	
		2. ANTECEDENT CAUSE(S) DUE TO	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE	
		STATING UNDERLYING CAUSE LAST.	
		3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
		<i>Bilateral coronary disease</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10-15</i>, 19<i>55</i>, to <i>2-15</i>, 19<i>56</i>, that I last saw the deceased alive on <i>2-14</i>, 19<i>56</i>, and that death occurred at <i>10:4</i> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>E. H. Richel, M.D.</i>		<i>2-15-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<i>Burial</i>		<i>Innocent E. Dougherty</i>	
DATE THEREOF		REGISTRAR'S SIGNATURE	
<i>2-18-56</i>		<i>Philos</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Philos</i>		<i>Western Port, Md</i>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Lee A. Peterson & Son, Perryville, Md</i>			

1100 CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX OF BIRTH

12. AGE AT BIRTH

13. OCCUPATION AT BIRTH

14. CAUSE OF BIRTH

15. MANNER OF BIRTH

16. DATE OF BIRTH

17. TIME OF BIRTH

18. PLACE OF BIRTH

19. DATE OF BIRTH

20. SEX OF BIRTH

21. AGE AT BIRTH

22. OCCUPATION AT BIRTH

23. CAUSE OF BIRTH

24. MANNER OF BIRTH

25. DATE OF BIRTH

26. TIME OF BIRTH

27. PLACE OF BIRTH

28. DATE OF BIRTH

29. SEX OF BIRTH

30. AGE AT BIRTH

31. OCCUPATION AT BIRTH

32. CAUSE OF BIRTH

33. MANNER OF BIRTH

34. DATE OF BIRTH

35. TIME OF BIRTH

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. SEX OF BIRTH

39. AGE AT BIRTH

40. OCCUPATION AT BIRTH

41. CAUSE OF BIRTH

42. MANNER OF BIRTH

43. DATE OF BIRTH

44. TIME OF BIRTH

45. PLACE OF BIRTH

46. DATE OF BIRTH

47. SEX OF BIRTH

48. AGE AT BIRTH

49. OCCUPATION AT BIRTH

50. CAUSE OF BIRTH

51. MANNER OF BIRTH

52. DATE OF BIRTH

53. TIME OF BIRTH

54. PLACE OF BIRTH

55. DATE OF BIRTH

56. SEX OF BIRTH

57. AGE AT BIRTH

58. OCCUPATION AT BIRTH

59. CAUSE OF BIRTH

60. MANNER OF BIRTH

61. DATE OF BIRTH

62. TIME OF BIRTH

63. PLACE OF BIRTH

64. DATE OF BIRTH

65. SEX OF BIRTH

66. AGE AT BIRTH

67. OCCUPATION AT BIRTH

68. CAUSE OF BIRTH

69. MANNER OF BIRTH

70. DATE OF BIRTH

71. TIME OF BIRTH

72. PLACE OF BIRTH

73. DATE OF BIRTH

74. SEX OF BIRTH

75. AGE AT BIRTH

76. OCCUPATION AT BIRTH

77. CAUSE OF BIRTH

78. MANNER OF BIRTH

79. DATE OF BIRTH

80. TIME OF BIRTH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX OF BIRTH

84. AGE AT BIRTH

85. OCCUPATION AT BIRTH

86. CAUSE OF BIRTH

87. MANNER OF BIRTH

88. DATE OF BIRTH

89. TIME OF BIRTH

90. PLACE OF BIRTH

91. DATE OF BIRTH

92. SEX OF BIRTH

93. AGE AT BIRTH

94. OCCUPATION AT BIRTH

95. CAUSE OF BIRTH

96. MANNER OF BIRTH

97. DATE OF BIRTH

98. TIME OF BIRTH

99. PLACE OF BIRTH

100. DATE OF BIRTH

101. SEX OF BIRTH

102. AGE AT BIRTH

103. OCCUPATION AT BIRTH

104. CAUSE OF BIRTH

105. MANNER OF BIRTH

106. DATE OF BIRTH

107. TIME OF BIRTH

108. PLACE OF BIRTH

109. DATE OF BIRTH

110. SEX OF BIRTH

111. AGE AT BIRTH

112. OCCUPATION AT BIRTH

113. CAUSE OF BIRTH

114. MANNER OF BIRTH

115. DATE OF BIRTH

116. TIME OF BIRTH

117. PLACE OF BIRTH

118. DATE OF BIRTH

119. SEX OF BIRTH

120. AGE AT BIRTH

121. OCCUPATION AT BIRTH

122. CAUSE OF BIRTH

123. MANNER OF BIRTH

124. DATE OF BIRTH

125. TIME OF BIRTH

126. PLACE OF BIRTH

127. DATE OF BIRTH

128. SEX OF BIRTH

129. AGE AT BIRTH

130. OCCUPATION AT BIRTH

131. CAUSE OF BIRTH

132. MANNER OF BIRTH

133. DATE OF BIRTH

134. TIME OF BIRTH

135. PLACE OF BIRTH

136. DATE OF BIRTH

137. SEX OF BIRTH

138. AGE AT BIRTH

139. OCCUPATION AT BIRTH

140. CAUSE OF BIRTH

141. MANNER OF BIRTH

142. DATE OF BIRTH

143. TIME OF BIRTH

144. PLACE OF BIRTH

145. DATE OF BIRTH

146. SEX OF BIRTH

147. AGE AT BIRTH

148. OCCUPATION AT BIRTH

149. CAUSE OF BIRTH

150. MANNER OF BIRTH

151. DATE OF BIRTH

152. TIME OF BIRTH

153. PLACE OF BIRTH

154. DATE OF BIRTH

155. SEX OF BIRTH

156. AGE AT BIRTH

157. OCCUPATION AT BIRTH

158. CAUSE OF BIRTH

159. MANNER OF BIRTH

160. DATE OF BIRTH

161. TIME OF BIRTH

162. PLACE OF BIRTH

163. DATE OF BIRTH

164. SEX OF BIRTH

165. AGE AT BIRTH

166. OCCUPATION AT BIRTH

167. CAUSE OF BIRTH

168. MANNER OF BIRTH

169. DATE OF BIRTH

170. TIME OF BIRTH

171. PLACE OF BIRTH

172. DATE OF BIRTH

173. SEX OF BIRTH

174. AGE AT BIRTH

175. OCCUPATION AT BIRTH

176. CAUSE OF BIRTH

177. MANNER OF BIRTH

178. DATE OF BIRTH

179. TIME OF BIRTH

180. PLACE OF BIRTH

181. DATE OF BIRTH

182. SEX OF BIRTH

183. AGE AT BIRTH

184. OCCUPATION AT BIRTH

185. CAUSE OF BIRTH

186. MANNER OF BIRTH

187. DATE OF BIRTH

188. TIME OF BIRTH

189. PLACE OF BIRTH

190. DATE OF BIRTH

191. SEX OF BIRTH

192. AGE AT BIRTH

193. OCCUPATION AT BIRTH

194. CAUSE OF BIRTH

195. MANNER OF BIRTH

196. DATE OF BIRTH

197. TIME OF BIRTH

198. PLACE OF BIRTH

199. DATE OF BIRTH

200. SEX OF BIRTH

201. AGE AT BIRTH

202. OCCUPATION AT BIRTH

203. CAUSE OF BIRTH

204. MANNER OF BIRTH

205. DATE OF BIRTH

206. TIME OF BIRTH

207. PLACE OF BIRTH

208. DATE OF BIRTH

209. SEX OF BIRTH

210. AGE AT BIRTH

211. OCCUPATION AT BIRTH

212. CAUSE OF BIRTH

213. MANNER OF BIRTH

214. DATE OF BIRTH

215. TIME OF BIRTH

216. PLACE OF BIRTH

217. DATE OF BIRTH

218. SEX OF BIRTH

219. AGE AT BIRTH

220. OCCUPATION AT BIRTH

221. CAUSE OF BIRTH

222. MANNER OF BIRTH

223. DATE OF BIRTH

224. TIME OF BIRTH

225. PLACE OF BIRTH

226. DATE OF BIRTH

227. SEX OF BIRTH

228. AGE AT BIRTH

229. OCCUPATION AT BIRTH

230. CAUSE OF BIRTH

231. MANNER OF BIRTH

232. DATE OF BIRTH

233. TIME OF BIRTH

234. PLACE OF BIRTH

235. DATE OF BIRTH

236. SEX OF BIRTH

237. AGE AT BIRTH

238. OCCUPATION AT BIRTH

239. CAUSE OF BIRTH

240. MANNER OF BIRTH

241. DATE OF BIRTH

242. TIME OF BIRTH

243. PLACE OF BIRTH

244. DATE OF BIRTH

245. SEX OF BIRTH

246. AGE AT BIRTH

247. OCCUPATION AT BIRTH

248. CAUSE OF BIRTH

249. MANNER OF BIRTH

250. DATE OF BIRTH

251. TIME OF BIRTH

252. PLACE OF BIRTH

253. DATE OF BIRTH

254. SEX OF BIRTH

255. AGE AT BIRTH

256. OCCUPATION AT BIRTH

257. CAUSE OF BIRTH

258. MANNER OF BIRTH

259. DATE OF BIRTH

260. TIME OF BIRTH

261. PLACE OF BIRTH

262. DATE OF BIRTH

263. SEX OF BIRTH

264. AGE AT BIRTH

265. OCCUPATION AT BIRTH

266. CAUSE OF BIRTH

267. MANNER OF BIRTH

268. DATE OF BIRTH

269. TIME OF BIRTH

270. PLACE OF BIRTH

271. DATE OF BIRTH

272. SEX OF BIRTH

273. AGE AT BIRTH

274. OCCUPATION AT BIRTH

275. CAUSE OF BIRTH

276. MANNER OF BIRTH

277. DATE OF BIRTH

278. TIME OF BIRTH

279. PLACE OF BIRTH

280. DATE OF BIRTH

281. SEX OF BIRTH

282. AGE AT BIRTH

283. OCCUPATION AT BIRTH

284. CAUSE OF BIRTH

285. MANNER OF BIRTH

286. DATE OF BIRTH

287. TIME OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate shall be filed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed certificate shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1707
CERTIFICATE OF DEATH

01691

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 mo. 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital		d. STREET ADDRESS Abingdon 12X-2	
3. NAME OF DECEASED (Type or print) First William Middle A. Schirling Last		4. DATE OF DEATH February 21 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-02
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Schirling - Deceased		14. MOTHER'S MAIDEN NAME Lida Badt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Peacetime & WWII unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphoma, Hodgkins disease of ribs, cervical & thoracic vertebra, right hip and skull (c) Arteriosclerosis, general, moderate		INTERVAL BETWEEN ONSET AND DEATH 3-4 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-28, 19 55, to 2-21, 19 56, and that death occurred at 3:00 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED 2-21-56	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-21-56	
22c. NAME OF CEMETERY OR CREMATORY Smith Chapel		22d. LOCATION (City, town, or county) (State) Churchville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McComas & Son, Abingdon, Maryland		24a. REC'D BY REGISTRAR DATE Feb. 21, 1956	
		24b. REGISTRAR'S SIGNATURE Susan E. Langherty	

FEB 23 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1708 CERTIFICATE OF DEATH

01692

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Route 3, Elkton HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Route 3, Elkton, Md. X STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) HATTIE I. SIMPERS		4. DATE OF DEATH (Month) (Day) (Year) Feb. 29, 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 27, 1874
9. AGE last birthday 81 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. Hunter Mahoney		14. MOTHER'S MAIDEN NAME Elizabeth Heak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Mrs. Elizabeth S. Rogers, R. D. 3, Elkton, Md. (daughter)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 525X IMMEDIATE CAUSE (A) Chronic Myocarditis ANTECEDENT CAUSE(S) DUE TO (B) Chronic Bilateral Filariis of lung DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 months 2 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/22, 1954, to 2/29, 1956, that I last saw the deceased alive on 2/27, 1956, and that death occurred at 1:00 P.M. from the causes and on the date stated above. SIGNATURE <i>Ralph E. Hicks</i> M.D. <i>Elkton 179</i> ADDRESS (Street, city, town, state) DATE SIGNED 3/1/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 3, 1956	
NAME OF CEMETERY OR CREMATORY Union Cemetery		LOCATION (City, town, or county) Cecil County, Maryland	
24. REC'D. BY REGISTRAR DATE 3/2/56		REGISTRAR'S SIGNATURE <i>JR Frazer</i>	
25. FUNERAL DIRECTOR'S SIGNATURE DATE 3/2/56		ADDRESS Bow & Stockton Sts. Elkton, Maryland	

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (If any)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. DATE OF DEATH (Month, day, year)

9. TIME OF DEATH (Hour, minute)

10. CAUSE OF DEATH (Immediate cause)

11. MANNER OF DEATH (Natural, Accidental, Homicide, Suicide)

12. SIGNATURE OF PHYSICIAN (Print name)

13. SIGNATURE OF PHYSICIAN (Signature)

14. SIGNATURE OF PHYSICIAN (Title)

15. SIGNATURE OF PHYSICIAN (Address)

16. SIGNATURE OF PHYSICIAN (City, State, Country)

17. SIGNATURE OF PHYSICIAN (Date)

18. SIGNATURE OF PHYSICIAN (Time)

19. SIGNATURE OF PHYSICIAN (Place)

20. SIGNATURE OF PHYSICIAN (Signature)

21. SIGNATURE OF PHYSICIAN (Title)

22. SIGNATURE OF PHYSICIAN (Address)

23. SIGNATURE OF PHYSICIAN (City, State, Country)

24. SIGNATURE OF PHYSICIAN (Date)

25. SIGNATURE OF PHYSICIAN (Time)

26. SIGNATURE OF PHYSICIAN (Place)

27. SIGNATURE OF PHYSICIAN (Signature)

28. SIGNATURE OF PHYSICIAN (Title)

29. SIGNATURE OF PHYSICIAN (Address)

30. SIGNATURE OF PHYSICIAN (City, State, Country)

31. SIGNATURE OF PHYSICIAN (Date)

32. SIGNATURE OF PHYSICIAN (Time)

33. SIGNATURE OF PHYSICIAN (Place)

34. SIGNATURE OF PHYSICIAN (Signature)

35. SIGNATURE OF PHYSICIAN (Title)

36. SIGNATURE OF PHYSICIAN (Address)

37. SIGNATURE OF PHYSICIAN (City, State, Country)

38. SIGNATURE OF PHYSICIAN (Date)

39. SIGNATURE OF PHYSICIAN (Time)

40. SIGNATURE OF PHYSICIAN (Place)

41. SIGNATURE OF PHYSICIAN (Signature)

42. SIGNATURE OF PHYSICIAN (Title)

43. SIGNATURE OF PHYSICIAN (Address)

44. SIGNATURE OF PHYSICIAN (City, State, Country)

BUREAU V. S.

MAR 5 1950

RECEIVED

1709

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) Perry Point		LENGTH OF STAY (in this place) 3 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 1131 W. Ostend			
3. NAME OF DECEASED: (First) (Middle) (Last) CHARLES E. TRAUNMILLER				4. DATE (Month) (Day) (Year) OF DEATH: February 12 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 7-3-95	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Records Clerk		10B. KIND OF BUSINESS OR INDUSTRY: VA Regional Office		11. BIRTHPLACE (State or foreign country): Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Baltimore, Md. Alois Traunmiller - Deceased				14. MOTHER'S MAIDEN NAME: Lulu Baber - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Bronchopneumonia, tuberculous						3 to 4 days	
ANTECEDENT CAUSE (S) Pulmonary tuberculosis, bilateral, active						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerosis generalized, moderate,						unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. severe							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-9 , 19 56 , to 2-12 , 19 56 , and that death occurred at 9:37 PM , from the causes and on the date stated above. SIGNATURE W. Oppler ADDRESS VAH, Perry Point, Md. DATE SIGNED 2-15-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 2-14-56		NAME OF CEMETERY OR CREMATORY Unknown		LOCATION (City, town, or county) (State) Missouri	
DATE REC'D BY LOCAL REGISTRAR 2-15-56		REGISTRAR'S SIGNATURE Joane E. Dougherty		24. FUNERAL DIRECTOR Pennington & Sons		ADDRESS Havre de Grace, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 20 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1710 Item 17: film G197 5-21-56 L
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01684 Dist.
 Item 7 film G196 11-25-56 at
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 91

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Cecil</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chesapeake City</u>	LENGTH OF STAY (in this place) <u>23 yrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Chesapeake City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Charles</u>		STREET ADDRESS (If rural, give location) <u>Charles</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>THOMAS</u>	(Middle) <u>BENNETT</u>	(Last) <u>VEALE</u>	(Month) <u>2</u> (Day) <u>19</u> (Year) <u>56</u>
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>Col.</u>	8. DATE OF BIRTH: <u>8-29-1907</u>	9. AGE last birthday: <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Electrician</u>	11. BIRTHPLACE (State or foreign country): <u>Chesapeake City Md.</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Henry Veale</u>		14. MOTHER'S MAIDEN NAME: <u>Hannie Wallace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>248-18-3286</u>	
17. INFORMANT & ADDRESS: <u>May Veale, Chesapeake City Md.</u>			
18. MEDICAL CERTIFICATION <u>CARTER</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Left lobar Pneumonia</u>			
DUE TO			
Antecedent cause(s) (b)			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>R. LeDochon</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-19-56</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>2/22/56</u>	NAME OF CEMETERY OR CREMATORY: <u>Bohemia Manor Cem.</u>	LOCATION (City, town, or county) (State): <u>Bohemia Manor, Md.</u>
DATE REC'D BY LOCAL REG. <u>February 22-1956</u>	REGISTRAR'S SIGNATURE: <u>Wm. Wallace & Sons</u>	24. FUNERAL DIRECTOR: <u>Charles Bell</u>	ADDRESS: <u>909 Poplar St.</u>

RECEIVED

FEB 24 1936

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01695

1711 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		LENGTH OF STAY (in this place) <u>1 mo. 23 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>SV01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>3608 E. Lombard</u>					
3. NAME OF DECEASED (Type or Print) <u>JOSEPH F. WELLS</u>				4. DATE OF DEATH (Month) <u>February</u> (Day) <u>28</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-25-16</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stave Joiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barrel Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Wells</u>				14. MOTHER'S MAIDEN NAME <u>Dora Wayland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records, VAH, Perry Point, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Hemorrhage, massive, into the gastro-intestinal tract</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Varix of esophagus, multiple, ruptured</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coarse nodular cirrhosis</u>						<u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis general, mild</u>						<u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>VA</u> <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 5</u> , 19 <u>56</u> , to <u>Feb. 28</u> , 19 <u>56</u> , and that death occurred at <u>7:40p</u> M., from the causes and on the date stated above.							
SIGNATURE <u>J.C. GRASBERGER</u>				DATE SIGNED <u>2-29-56</u>			
J.C. GRASBERGER, Actg. Director, Services M.D. V.A. Hospital, Perry Point, Md.							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>2-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>3-1-56</u>		REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington & Sons, Hagerstown, Md.</u>			

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. No. 100-1000000

1. Name of deceased (Print or write)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death (Print or write)

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of record

20. Signature of file

21. Signature of index

22. Signature of distribution

23. Signature of return

24. Signature of receipt

25. Signature of acknowledgment

26. Signature of completion

27. Signature of final

28. Signature of record

BUREAU V. S.

MAR 2 1956

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